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No. 85-632

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner of the Massachusetts Department of Public Welfare,
Petitioner,

v.

SANTOS RIVERA, MADELINE MCKENNA, and all others similarly situated,
Respondents.

On Writ Of Certiorari To The Supreme Judicial Court Of Massachusetts

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BRIEF FOR RESPONDENT McKENNA

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QUESTIONS PRESENTED

Whether a State violates the Social Security Act requirement that medical assistance ("Medicaid") income eligibility must be determined using the same methodology as it uses in determining income eligibility for Aid to Families with Dependent Children ("AFDC"), when the State counts six months' income in determining Medicaid eligibility but counts only one month's income in determining AFDC eligibility?

Whether the policy of the Department of Health and Human Services ("HHS") allowing States to determine Medicaid income eligibility for a period of up to six months is entitled to any judicial deference, when Congress had previously delegated legislative authority to the Secretary of HHS to prescribe standards for such determinations of income eligibility, but has since withdrawn that delegation?

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STATEMENT OF THE CASE

Respondents, mothers of minor children, applied for medical assistance ("Medicaid") for the medically needy.[1] Their applications were denied, and their administrative hearings challenging those denials were unsuccessful. In those administrative "fair hearings" the referee held that their "net income and six month surplus" were correctly computed [Pet. A52, A59].

Respondent Rivera commenced this class action [J.A. 11-12],[2] and respondent McKenna intervened as a plaintiff [J.A. 32]. Both complaints alleged that the Massachusetts

> policy and practice of using a six month period for calculating the income of AFDC-related medically needy applicants for and recipients of Medicaid violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III) insofar as it employs a different budgeting methodology to determine their Medicaid eligibility than is used to determine eligibility for the AFDC program. [J.A. 21, 43.]

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[1] States are generally required to provide Medicaid for recipients of federally financed cash public assistance benefits, *i.e.*, children and caretaker relatives receiving Aid to Families with Dependent Children ("AFDC") benefits [42 U.S.C. §§ 601 *et seq.*] and the aged, blind and disabled receiving Supplemental Security Income ("SSI") benefits [42 U.S.C. §§ 1381 *et seq.*]. These are the "categorically needy." 42 C.F.R. § 435.4. Respondents are "medically needy," *i.e.* persons who would be categorically needy except for excess income or resources. *Id.* Because respondents were categorically eligible for AFDC they and the class [Pet. A65] are "AFDC-related." As the Petition (p. 16) concedes, the analysis in this case applies with equal force to the "SSI-related" group of aged, blind and disabled medically needy Medicaid applicants. Whether the Massachusetts policy of calculating eligibility on a six-month basis for the SSI-related violates the Social Security Act is the issue in *Hogan* v. *Bowen*, *petition for certiorari docketed* No. 85-6386 (U.S. Feb. 14, 1986).

[2] References "J.A." are to the Joint Appendix.

Ms. Rivera was employed full time and had gross monthly income of only $610.30. After applying a standard deduction of $75.00 for all her taxes and other work expenses, Massachusetts computed her net monthly income as $535.30. Since that was $100.30 more than the monthly Medicaid income allowance for a family of three, Ms. Rivera and her two children (then aged 11 and 13 [R.57][3] were only eligible for Medicaid if, during the six-month eligibility period, she became liable for $601.80 of medical bills—six times their monthly excess income [Pet. A50-A52].[4] The Riveras were thus determined ineligible despite incurring $314.00 of unpaid medical bills, more than one-half their gross monthly income, in one month alone [R. 73-74].

Ms. McKenna was also a working mother with a 13-year-old child [R. 121]. She had net monthly income of $531.66 (after the standard $75.00 tax and work expense deduction) which was $106.66 more than the Medicaid income allowance of $425.00 monthly for a family of two [Pet. A57]. Accordingly Massachusetts determined that the McKennas would only be eligible for Medicaid once they incurred $639.96 of medical bills (6 x $106.66) for the six-month eligibility period [*Id.*].[5]

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[3] References "R" are to the Record Appendix below.

[4] The medically needy are eligible for Medicaid if they incur medical expenses which exceed the difference between their net income (gross income less $75.00 for work expenses for respondents under Massachusetts law) and the Medicaid eligibility level. In Medicaid jargon this is their "spend-down." That term does not appear in the Social Security Act or federal Medicaid regulations; it is administrative shorthand for another of many deductions from income used in determining Medicaid income eligibility.

[5] The State's brief (p. 16, n.18) suggests for the first time that the McKennas' eligibility was not actually affected by the six-month

The trial court granted respondents' summary judgment motion [J.A. 54], holding that the State's policy of determining Medicaid applicants' income on a semi-annual basis while determining AFDC eligibility by examining income on a monthly basis violated the requirement[6] that the State determine Medicaid income eligibility for the AFDC-related medically needy using the same methodology that it uses to determine AFDC income eligibility for the categorically needy [Pet. A39-A42]. The trial court rejected as "totally without merit" the contention the State renews in this Court that its six-month computation was not a determination of income eligibility [Pet. A41].

The trial court likewise rejected another argument the State raises in this Court, that its six-month income eligibility rule is authorized by 42 C.F.R. § 435.831. The trial court held that 42 U.S.C. § 1396a(a)(10)(C)(i)(III), enacted after the promulgation of 42 C.F.R. § 435.831, controlled over the regulation [Pet. A43]. Accordingly it entered judgment (as amended in respects not relevant here) certifying a class of AFDC-related medically needy

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income determination. This is incorrect. Since it was not raised below, the record is not developed on this point, but it is a fact that because she fell behind on the $70.00 monthly payments for her son's dental care Ms. McKenna paid $190.00 in January, 1984, and $140.00 in November, 1984. Federal policy permits an applicant to use unpaid back bills to meet a given month's obligation, so the McKennas would have been Medicaid eligible (using one-month income eligibility) in, *e.g.* November, 1984, since they presented unpaid $70.00 dental bills for October and November. *See* 48 Fed.Reg. 39960, 39961 (1983). In any event the case was certified as a class action and no question has been raised as to the adverse effect the State's policy had on the other class representative, respondent Rivera.

[6] Under 42 U.S.C. § 1396a(a)(10)(C)(i)(III).

Medicaid applicants or recipients subjected to the six-month spend-down requirement [Pet. A65], declaring that the six-month requirement violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III) [Pet. A66], enjoining use of a spend-down requirement of more than one month [Pet. A67], and requiring eligibility recomputations on a monthly basis [Pet. A68-A69].

On appeal by the Commissioner of Public Welfare the Massachusetts Supreme Judicial Court affirmed on the issue presented in this Court [Pet. A23-27]. It held that the issue was not, as the State argued and still argues in this Court, that AFDC has no spend-down, but rather that whatever budget period is used to determine income eligibility for AFDC must be used for Medicaid eligibility as well as [Pet. A25]. It thus agreed with the trial court that the State's use of a six-month income budgeting period violated 42 U.S.C. § 1396a(a)(10)(C)(i)(III) [Pet. A26-A27] and entered judgment accordingly [Pet. A61-A62].

On the petition of the Commissioner of the Massachusetts Department of Public Welfare, this Court granted a writ of certiorari to review the judgment of the Massachusetts Supreme Judicial Court that the use of a six-month income budget period violates 42 U.S.C. § 1396a(a)(10)(C)(i)(III).[7] ___ U.S. ___, 106 S.Ct. 566 (1985).

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[7] While petitioner and the *amici* supporting petitioner have also briefed whether the State's policy violates 42 U.S.C. § 1396a(a)(17), that issue is premature and respondent does not rely on that section in defense of the judgment. That issue, if it ever needs to be addressed, should be left to another day. The courts below did not rely on § 1396a(a)(17), and, in respondent's view, § 1396a(a)(10)(C)(i)(III) is determinative of this case. Hence respondent declines the invitation to join issue here on whether the State's policy also violates § 1396a(a)(17).

SUMMARY OF ARGUMENT

1. The statute in question, 42 U.S.C. § 1396a(a)(10)-(C)(i)(III), concerns the State's policy for "determining income . . . eligibility," and requires that it be determined using the same methodology as the State uses under AFDC. Income eligibility for AFDC (and for SSI) is determined on a monthly basis, and the Medicaid statute incorporates that same requirement by requiring the use of the same methodology for determining income eligibility as is used by AFDC [P. 8].

It is impossible to determine "income" without regard to a period of time. Time is an essential element in the measure of income. The statute should be construed in light of the ordinary meaning of "income" as involving a time factor [P. 10].

2. The statute has a plain meaning which does not justify any deference to the interpretation given it by the Secretary of the Department of Health and Human Services ("HHS"). The medically needy respondents are statutorily defined with reference to AFDC income eligibility, and it was the intent of Congress that the needs and means of the AFDC-related medically needy be measured with reference to AFDC [P. 10].

Since an AFDC applicant is determined eligible on a monthly basis, based on one month's income, the statute and legislative history support the judgment below that a medically needy Medicaid applicant must likewise have her eligibility determined on a monthly basis based on one month's income [P. 13].

3. Prior to a series of statutory changes that were made starting in 1981, the Secretary of HHS (the

"Secretary") had been vested with legislative authority to prescribe the standards for State Medicaid income eligibility determinations. That former version of the statute merely required that, pursuant to the Secretary's standards, the medically needy have eligibility rules "comparable" to those of the categorically needy [P. 16].

Under that delegation for defining "comparable" standards the Secretary accommodated the then existing outside parameters of Medicaid eligibility by authorizing States to determine income for periods of up to six months. SSI eligibility, and the Medicaid eligibility that automatically goes with it, were then determined on the basis of quarterly (3-months') income, and separate Medicaid eligibility was available for the three months prior to the month of application. Thus, for the medically needy, the Secretary had to have a rule allowing up to six months' income to be counted in order to accommodate coverage of up to six months, just as six months' coverage was available for categorically needy SSI applicants [P. 18].

4. In 1981 Congress revised the "comparability" language, but it intended to retain the doctrine that the medically needy have their eligibility determined no more restrictively than their categorically needy counterparts. The Secretary ignored this legislative history and authorized States to use more "flexible" standards [P. 19].

In 1981, in the same Act in which it enacted the amended version of 42 U.S.C. § 1396a(a)(10)(C) that the Secretary eventually misconstrued, Congress also mandated for the first time that AFDC and SSI income eligibility determinations be done on a monthly basis. Since the Secretary ignored the stated intent of Congress in amending 42 U.S.C. § 1396a(a)(10)(C), it is no wonder that the Secretary also ignored or overlooked the impact

of the one-month income budgeting requirement for AFDC and SSI [P. 20].

In response to the Secretary's disregard of its stated intent, Congress in 1982 enacted current 42 U.S.C. § 1396a(a)(10)(C)(i)(III), requiring that Medicaid income eligibility for the AFDC-related be determined using the same methodology as AFDC income eligibility. In light of the Secretary's refusal to abide by previous Congressional intent, Congress did not re-delegate legislative authority to the Secretary. This combination of factors requires that no judicial deference be given to the views of the Secretary as set forth in 42 C.F.R. § 435.831 and the *amicus curiae* brief of the United States [P. 20].

5. In enacting 42 U.S.C. § 1396a(a)(10)(C)(i)(III) in 1982 Congress did not intend to validate the six-month rule of 42 C.F.R. § 435.831 or to permit the Secretary to determine Medicaid income eligibility on other than the monthly basis then being used to determine AFDC and SSI income eligibility. The legislative history shows that Congress intended to require that there be at least an identity of treatment between the eligibility criteria for Medicaid and the eligibility criteria for AFDC and SSI. Congress clearly intended to restrict the Secretary's authority to permit variations between the eligibility determinations for Medicaid and those for AFDC and SSI in light of the prior disregard of the intent of Congress evidenced by the Secretary's misinterpretation of the 1981 amendments [P. 21].

The continued existence of 42 C.F.R. § 435.831 permitting six-month income eligibility determinations for Medicaid is not proof of its validity. Since HHS has stated that 42 U.S.C. § 1396a(a)(10)(C)(i)(III) is "self-implementing," Congress cannot be said to have ratified the regula-

tion by failing to repeal it since 1982. Congress likewise has not expressly reaffirmed the six-month regulation either [P. 23].

6. The six-month regulation, 42 C.F.R. § 435.831, cannot be justified as being based on a separate statutory "spend-down" concept authorized under the last clause of 42 U.S.C. § 1396a(a)(17). The "spend-down" simply represents another deduction from income, and since income is computed monthly under 42 U.S.C. § 1396a(a)(10)-(C)(i)(III) so must this deduction for incurred medical bills [P. 25].

The Secretary's regulations have always recognized that determining income eligibility based on net income, the issue here, under 42 U.S.C. § 1396a(a)(10)(C), is different from determining the sorts of medical bills that States need not deduct from income, the issue under the last clause of 42 U.S.C. § 1396a(a)(17). Thus the six-month regulation, 42 C.F.R. § 435.831, cannot be justified pursuant to the last clause of 42 U.S.C. § 1396a(a)(17) [P. 26].

ARGUMENT

POINT I

THE PLAIN MEANING OF 42 U.S.C. § 1396a(a)(10)(C) REQUIRES THAT MEDICAID INCOME ELIGIBILITY BE DETERMINED ON A MONTHLY BASIS

A. The Statute Concerns Determining Income Eligibility

The statute,[8] read in its entirety, prescribes how many months' income the State can count in making a Medicaid eligibility determination based on income. Under Section-

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[8] 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (hereinafter "Section III").

III, the State's plan for its Medicaid program must describe

> the single standard to be employed in *determining income . . . eligibility . . .* and the methodology to be employed in *determining such eligibility,* which shall be the same methodology which would be employed under [SSI or AFDC]. [Emphasis supplied.]

The State's focus on the word "methodology" ignores the rest of the statutory language which makes clear that this section concerns determining income eligibility.

Income, by definition, can only be determined over a stated period of time, and the related statutory provisions for determining income eligibility for AFDC and SSI naturally specify such a time period—one month.[9] That time period is thus incorporated into the requirements of Section III for determining Medicaid income eligibility as well.

B. Income Eligibility For AFDC And SSI Is Determined On A Monthly Basis

The AFDC statute states explicitly for what period income is to be counted in determining income eligibility for that program: States must "determine a family's eligibility for [AFDC] for a month on the basis of the family's income . . . during such month." 42 U.S.C. § 602(a)(13). The SSI statute is similar: "An individual's eligibility . . . for a month shall be determined on the basis of the individual's . . . income, resources, and other characteristics in such month . . . ." 42 U.S.C. § 1382(c)(1).

The statutes covering all three programs, Medicaid, AFDC, and SSI, all refer to determining eligibility on the

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[9] 42 U.S.C. §§ 602(a)(13) and 1382(c)(1), respectively.

basis of income. For the AFDC and SSI programs the statutes explicitly require that income eligibility determinations be based on a single month's income. For Medicaid Section III simply refers to determining income eligibility by referring to the "same methodology" that is used to determine income eligibility for AFDC or SSI. Plainly the Medicaid statute thus requires the use of one month's income, not six months', in determining income eligibility, just as is required for AFDC and SSI.

C. "Income" Is Meaningless Without A Time Component

The State's construction of Section III ignores the common understanding of the word "income." The starting point for construing this statute must be, "as always, the language of the statute." *Heckler* v. *Turner*, ___ U.S. ___, 105 S.Ct. 1138, 1144 (1985). The term "income" has consistently been construed by this Court and other courts as "[involving] time as an essential element in its measurement or definition." *Trefry* v. *Putnam*, 227 Mass. 522, 526, 116 N.E. 904, 907 (1917). As this Court has pointed out, resources, such as assets on a balance sheet, differ from income in that income is "measured by its flow during a period of time." *Eisner* v. *Macomber*, 252 U.S. 189, 206 (1920).

This common sense understanding of the word "income" is exemplified by looking at the situation of respondent McKenna. Saying that she has $531.66 of income says nothing of use. If that were her weekly income she would be "middle class." If that were her daily income she might be well to do. Since it is her monthly income she is poor.

D. Section III Should Be Given Its Ordinary Meaning And Does Not Require Technical Expertise To Be Understood

Section III is rendered meaningless if its reference to the "methodology to be employed in determining such

[income and resource] eligibility" does not encompass the period of time over which such income is measured. The language of the statute should be given its ordinary meaning, *Perrin* v. *United States*, 444 U.S. 37, 42 (1979). As it has in the past in cases dealing with defining "income," the Court should continue to "[refuse] to enter into the refinements of lexicographers" and should instead construe the statute in accord with "the commonly understood meaning. . . ." *Merchants' Loan & Trust Co.* v. *Smietanka*, 255 U.S. 509, 519 (1921).

It is the straightforward nature of the statutory phrase "determining income . . . eligibility" which distinguishes this case from *Connecticut Department of Income Maintenance* v. *Heckler*, ___ U.S. ___, 105 S.Ct. 2210 (1985).[10] There the issue was how to define the term "institution for mental diseases" in the absence of a statutory definition. *Id.*, 105 S.Ct. at 2214. Because of the vagueness of the term the Court gave deference to the Secretary's definition of it, just as it had given deference to the agency in deciding whether or not the "bubble concept" applied to a "stationary source" of pollutants in *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778 (1984).

Defining the phrase "determining income . . . eligibility" is a far cry from defining a "stationary source" or even an "institution for mental diseases." In this case, unlike *Connecticut* and *Chevron*, technical expertise is not required. Rather, the definition at issue here is like the clear cut definition of a "bank" in *Board of Governors*

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[10] *Connecticut* further differs from this case in that, unlike here, Congress had not previously granted the Secretary legislative authority to establish rules and then withdrawn that authority. *See* Point II(B), *infra*.

of the Federal Reserve System v. *Dimension Financial Corp.*, ___ U.S. ___, 106 S.Ct. 681 (U.S. 1986). There this Court unanimously rejected the Federal Reserve Board's definition of a bank, which conflicted with the definition Congress had provided in the statute. Here Congress has likewise defined how income eligibility for AFDC and SSI is to be determined—on a monthly basis—and it has incorporated those definitions into Section III for Medicaid.

It was, in part, a failure to follow the analytical framework of *Chevron* that led the Second Circuit to err by upholding the six-month regulation in *DeJesus* v. *Perales*, 770 F.2d 316 (2d Cir. 1985), *petition for certiorari docketed* No. 85-6337 (U.S. Feb. 7, 1986). *Chevron* recognizes that where the statute is clear "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc.* v. *National Resources Defense Council, Inc.*, *supra*, 467 U.S. at ___, 104 S.Ct. at 2781-2782. Only where the statute is not clear, on its face or analyzed by traditional tools of statutory construction such as legislative history and the context of statutory amendments, does a court even go to the next step of considering an agency's interpretation.

In *DeJesus* the court erred by ignoring the language of the statute, viewed in the context of the 1981-1982 addition of a requirement for determining AFDC and SSI income on a monthly basis and enactment of Section III, and instead deferring to the Secretary. The *DeJesus* court stated that it had to guard against "allowing a *literal reading* of a relatively recent amendment to set at naught the experience of administrators acquired over a score of years." *DeJesus* v. *Perales*, *supra*, 770 F.2d at 321 [emphasis supplied]. Of course, *Chevron* teaches that the "literal reading" of a statute necessarily prevails over a

contrary administrative interpretation no matter how long-standing the agency's interpretation might be. *Accord, SEC* v. *Sloan*, 436 U.S. 103, 117-119 (1978). On the issue of whether the statute is clear the views of the agency are entitled to no greater respect than those of any other litigant.

Respondent here agrees with the Second Circuit that a "literal reading" of the statute supports her position. That should be the end of the inquiry. "Congress . . . did not empower the [Secretary], after the manner of Humpty Dumpty in Through the Looking Glass, to make a regulation . . . by his mere designation." *Adamo Wrecking Co.* v. *United States*, 434 U.S. 275, 283 (1978). This is inherent in the separation of powers between Congress and the executive branch. Moreover, as set forth, *infra*, it is precisely the series of "relatively recent amendment[s]," *DeJesus*, *supra*, that confirm respondent's interpretation.

E. Determining Income Eligibility On A Monthly Basis Accords With The Statutory Definition Of The Medically Needy And The Intent Of Congress

This Court has previously recognized that the income limitations of the related cash program define Medicaid eligibility for those who are not categorically needy AFDC or SSI applicants. *Herweg* v. *Ray*, 455 U.S. 265, 276 (1982) [involving the "optional categorically needy"].[11] The use of the same period for counting income

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[11] This principle is not undercut by *Schweiker* v. *Hogan*, 457 U.S. 569 (1982). There the general requirements for comparable treatment of the medically needy and categorically needy under another statute, 42 U.S.C. § 1396a(a)(17), were overcome by a specific statutory limitation capping the Medicaid income level even if that cap fell below the level for SSI eligibility. Without such a specific statutory exception States cannot use more restrictive rules for determining

for determining Medicaid eligibility as for determining AFDC eligibility is further in accord with the intent of Congress in enacting Medicaid. The medically needy program was intended to cover "persons who would qualify under [*e.g.*, AFDC] if in sufficient need." 111 Cong. Rec. 7216 (1965) (remarks of Rep. Mills). The program requires "that the means test for medical assistance be the same as that applied to applicants for cash benefits under other State public assistance programs." 111 Cong. Rec. 15804 (1965) (remarks of Sen. Ribicoff).

The undisputed fact is that a categorically needy applicant for AFDC (or for SSI) has his or her eligibility determined on a monthly basis, based on a month's income, and receives Medicaid as part of his or her benefits.[12] Such an applicant can receive Medicaid for as little as a single month. For respondents and the class, however, there is no one month Medicaid eligibility. For respondents and the class, eligibility, and the income for determining it, are always measured over six months.

The State's argument in favor of its six-month policy ignores the fact that the methodology for determining income eligibility cannot be isolated from the time factor inherent in measuring income, and it ignores both the statutory language and the Congressional intent defining Medicaid eligibility in relation to income eligibility for cash benefits. The only interpretation of the statute that makes sense and accords with the statutory language and Congressional intent is that adopted by the court below.

Medicaid eligibility than the eligibility rules used for the cash programs. *See Beltran* v. *Myers*, 451 U.S. 625, 629 (1981) (concurring opinion) [four members of this Court agreed on this point; the other five Justices did not reach the issue].

[12] 42 U.S.C. § 1396a(a)(10)(A)(i).

Since AFDC eligibility is determined on the basis of only one month's income, that same methodology must be used to determine Medicaid eligibility based on only one month's income.

POINT II

THE CURRENT VERSION OF 42 U.S.C. § 1396a(a)(10)(C) IS PART OF A SERIES OF STATUTORY CHANGES THAT REQUIRE ONE MONTH INCOME ELIGIBILITY DETERMINATIONS AND THAT HAVE SUPERSEDED 42 C.F.R. § 435.831

The construction of Section III adopted by the courts below, requiring that Medicaid income eligibility be determined based on one month's income, is the only construction that recognizes and is consistent with the series of statutory changes that culminated in the current statutory language. In 1981 Congress repealed the delegation of legislative authority to establish standards for determining income eligibility that it had previously granted to the Secretary under 42 U.S.C. § 1396a(a)(10)(C) [1980]. After the Secretary issued regulations that violated the Medicaid statute as amended in 1981 by Congress, the explicit mandate of Section III was enacted in 1982.

The Secretary's six-month regulation, 42 C.F.R. § 435.831, was adopted before monthly income budgeting was first required for the categorically needy, such as AFDC applicants, so before 1981 the regulation did not need to require monthly income budgeting for the medically needy in order to provide "comparable" standards. Moreover, since from 1974 until early 1982 Medicaid eligibility for SSI applicants could cover their quarterly SSI eligibility period plus the special retroactive three-month coverage period, or up to six months, the Secretary's regulation allowing up to six-month Medicaid budgeting

for the medically needy once made sense. A six-month eligibility period was "comparable" to that used for some of the categorically needy. Congress repealed its delegation of legislative authority to the Secretary, however, and the Secretary issued regulations that violated the Medicaid statute as enacted by Congress. As a result the explicit mandate of Section III was enacted, and the Secretary's regulation, 42 C.F.R. § 435.831 purporting to authorize the State's six-month income determinations, is now invalid as a result of this series of statutory changes.

A. The Former Delegation Of Legislative Authority And The Basis Of The Secretary's Six-Month Regulation Prior To 1981

Prior to 1981 the language of 42 U.S.C. § 1396a(a)(10)-(C) [1980] gave the Secretary greater leeway than current Section III in determining the rules for Medicaid income eligibility. The pre-1981 version of § 1396a(a)(10)-(C) provided that Medicaid income and resource eligibility was to be "determined in accordance with standards prescribed by the Secretary."[13] That language vested legislative authority in the Secretary, whose policies and regulations on the issue were thus entitled to virtually absolute judicial deference. *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 44 (1981); *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977).[14]

The pre-1981 version of the statute merely required that States choosing to cover the medically needy provide Medicaid for those whose income was "insufficient (as determined in accordance with comparable standards)

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[13] The full text of the pre-1981 version is set forth in the Appendix to this brief.

[14] As set forth, *infra*, Point II(B), this delegation of authority to the Secretary was withdrawn by Congress.

. . . to meet the costs of necessary medical and remedial care and services." 42 U.S.C. § 1396a(a)(10)(C)(i) [1980]. Whether or not the pre-1981 reference to "comparable standards" required that they be identical,[15] the delegation of legislative authority authorized the Secretary to harmonize that "comparability" mandate with other aspects of the various public welfare programs as they then existed. The Secretary did this by promulgating 42 C.F.R. § 435.831, which permitted, but did not require, States to determine income over a period of up to six months.

Prior to 1981 the Social Security Act was silent concerning the time period over which AFDC income eligibility was to be determined.[16] For SSI, until April, 1982,

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[15] *Cf. DeJesus* v. *Perales*, 770 F.2d 316, 324 (2d Cir. 1985), *petition for certiorari docketed* No. 85-6337 (U.S. Feb. 7, 1986), holding that "comparable" does not mean "identical" under similar language in 42 U.S.C. § 1396a(a)(17).

[16] The assertions to the contrary in the State's brief (p. 61) and the *amicus* brief of the United States (p. 26, n.15), relying on *DeJesus* v. *Perales*, *supra*, 770 F.2d at 323 n.9, are simply wrong. They cite 42 U.S.C. § 602(a)(8) [1976], a section providing for a monthly disregard of $30 plus 1/3 the remainder of earned income, but that section generally applied only to persons otherwise income eligible for AFDC without application of that disregard. It was not generally used for determining eligibility, and the Secretary successfully defended a constitutional challenge in this Court based on this distinction, *Conner* v. *Richardson*, 400 U.S. 1003 (1971), *aff'g Conner* v. *Finch*, 314 F.Supp. 364 (N.D.Ill. 1970). Less than a year ago the Secretary successfully defended against having to apply the $30 and 1/3 disregard to Medicaid eligibility since it was not applied to AFDC eligibility. *Zilska* v. *Mansour*, Civil No. 79-10093 (E.D.Mich. June 14, 1985), and the Secretary's regulations recognized this distinction also. 45 C.F.R. § 233.20(a)(7)(ii) [1980]. See also *McGraw* v. *Berger*, 537 F.2d 719, 721, 723 (2d Cir. 1976), *cert. denied* 429 U.S. 1095 (1977); S.Rep. No. 97-139, 97th Cong., 1st Sess., at 435, *reprinted in* [1981]

eligibility was generally determined on a quarterly basis.[17]

The Secretary thus had to have in place, prior to the 1982 change from quarterly to monthly income eligibility determinations for SSI, a regulation permitting Medicaid income eligibility determinations to be made based on at least three months' income for the SSI-related so that such Medicaid income eligibility determinations could be "comparable" to those used for SSI. Additionally, such a regulation also served as an outer limit to accommodate whatever variations States might wish to adopt for determining AFDC income eligibility.

The six-month limit of 42 C.F.R. § 435.831 made further sense prior to April, 1982, since the Secretary's regulations for the medically needy, in order to be "comparable" to the eligibility policies for the categorically needy, had to accommodate both quarterly SSI-related income eligibility determinations, *supra*, and a special period of Medicaid eligibility available for the three calendar months prior to the month of application under 42

U.S. Code Cong. & Admn. News 396, 701 ["The $30 and one-third applies only to those already on the rolls . . ."].

Equally inexplicable are their citations to 42 U.S.C. § 602(a)(28) [1976], which only applied "in determining the amount of aid to which an eligible family is entitled." That section did not apply to determining eligibility for AFDC either.

[17] The current monthly income eligibility determination for SSI under 42 U.S.C. § 1382(c)(1) was changed from the prior quarterly computation by Pub.L. No. 97-35, § 2341, 95 Stat. 865 (1981). *See* S.Rep. No. 97-139, 97th Cong., 1st Sess., at 442, *reprinted in* [1981] U.S. Code Cong. & Admn. News 396, 708.

U.S.C. § 1396a(a)(34).[18] The six-month limitation in 42 C.F.R. § 435.831 permitted the maximum coverage span of six months possible from a combination of the quarterly SSI income eligibility determination and the special three months' coverage under 42 U.S.C. § 1396a(a)(34).[19]

B. The Statutory Changes Requiring One Month Income Eligibility Determinations And The Withdrawal Of Legislative Authority From The Secretary

This situation of somewhat undefined statutory requirements for determining income eligibility, coupled with extensive discretion vested in the Secretary, was totally changed by the Ninety-seventh Congress in 1981 and 1982. In 1981 Congress mandated that both AFDC and SSI income eligibility determinations be made on the basis of one month's income. Pub. L. No. 97-35, §§ 2315(a) and 2341, 95 Stat. 855 and 865 (1981).[20] In that same bill Congress revised 42 U.S.C. § 1396a(a)(10)(C) to allow the States moderate flexibility in certain aspects of their Medicaid coverage, unrelated to income eligibility determina-

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[18] In fact, from its inception in the Handbook of Public Assistance Administration (Brief for Petitioner at A15) through September, 1978 (42 C.F.R. § 448.3(c)(4) [1977]), the six-month rule provided for the six months to start with the month services were rendered. Massachusetts follows this policy to date, including any of the three-month retroactive coverage in the six-month budget period. 106 C.M.R. § 506.510. While that has not been explicit since the regulations were recodified in 1978, the recodification made "no substantive changes." 43 Fed.Reg. 45176 (1978).

[19] The current version of 42 C.F.R. § 435.831, slightly differently worded and codified, was expressly stated as implementing both SSI and the mandatory 3-month coverage under § 1396a(a)(34). 38 Fed.Reg. 16309 (1973); 39 Fed.Reg. 9512, 9517 (1974).

[20] The Omnibus Budget Reconciliation Act of 1981 ["OBRA"].

tions. Pub.L. No. 97-35, § 2171(a)(3), 95 Stat. 807 (1981). The Secretary, however, seized upon that "flexibility" as an opportunity to revise the old "comparability" regulations to the point of virtually eliminating them. 46 Fed. Reg. 47976 (1981). The Secretary also ignored the effect of the new requirements that AFDC and SSI income eligibility be determined on a monthly basis.

Congress responded in 1982 by enacting the current stringent "same methodology" requirement of Section III[21] and expressly *not* re-delegating to the Secretary the legislative authority with regard to income eligibility determinations that had previously existed under that section since the Medicaid program's inception. The effect of such an express withdrawal of previously delegated legislative authority was ignored by the courts in *DeJesus* v. *Perales*, *supra*, and *Hogan* v. *Heckler*, 769 F.2d 886 (1st Cir. 1985), *petition for certiorari docketed sub nom Hogan* v. *Bowen*, No. 85-6386 (U.S. Feb. 14, 1986), on which petitioner relies. The failure of those courts to consider this withdrawal of the delegation of legislative authority to the Secretary completely undermines their analyses.

Subsequently Congress has consistently emphasized that the Secretary's interpretation of Section III is incorrect, and the Secretary has ignored Congress' views on that as well. As a result Congress has had to further restrict the Secretary's powers by enacting a "moratorium" on the Secretary imposing any sanctions on States for allegedly violating Section III by using more generous Medicaid budgeting than is used for AFDC or SSI. Pub.L. No. 98-369 § 2373(c), 98 Stat. 1112 (1984). *See also* the proposed Consolidated Omnibus Budget Recon-

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[21] Pub.L. No. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 ["TEFRA"], § 137(b)(8), 96 Stat. 378 (1982).

ciliation Act of 1985, H.R. 3128, § 9521, H.R. Conf. Rep. No. 99-453, 99th Cong., 1st Sess., at 156 and 552 (1985). Since it is Congress, not the Secretary, that enacts the laws, the Court should follow the expressed intent of Congress and give absolutely no deference whatsoever to the views of the Secretary as to the meaning of Section III.

In this unique situation where the previous delegation of legislative authority has been withdrawn, the necessary counterpoint to the heightened deference previously due under *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977) is to give no deference to the Secretary. Otherwise, under the sort of implicit delegation recognized in *Chevron* and *Connecticut Income Maintenance*, *supra*, the agency could still work mischief by regulation absent the most narrowly drawn statute. Plainly Congress intended to strip the Secretary of the otherwise customary power to reconcile different sections of the statute insofar as Medicaid income eligibility determinations were concerned. Accordingly the Secretary should be accorded no deference on this issue.

C. The Legislative History Demonstrates That 42 C.F.R. § 435.831 Has Been Statutorily Superseded

Nothing in the development of Section III suggests that Congress had any intent to validate the 6-month income counting regulation, 42 C.F.R. § 435.831, or any intent to vest authority in the Secretary to permit States to determine Medicaid income eligibility more restrictively than AFDC or SSI income eligibility is determined.

To the contrary, the legislative history indicates that the medically needy, like respondents, were not to have their eligibility determined more restrictively than their categorically needy counterparts. When Congress in 1981

repealed the former "comparability" language of 42 U.S.C. § 1396a(a)(10)(C)and the language delegating legislative authority to the Secretary, its stated intent was nonetheless to require at least "identical treatment for eligibility criteria . . . between the categorically needy and the medically needy programs." H.R. Conf. Rep. No. 97-208, 97th Cong., 1st Sess., at 971, *reprinted in* [1981] U.S. Code Cong. & Admn. News 1010, 1333.

What led up to the enactment of Section III in 1982 was the HHS response to the 1981 amendments that did precisely the opposite of what Congress intended. HHS issued regulations authorizing States to treat the medically needy more restrictively than the categorically needy in determining income and resource eligibility. 46 Fed. Reg. 47976 (1981). Six days after HHS issued those regulations Congress criticized them as "flatly inconsistent with the statute and the intent of the conferees." 127 Cong. Rec. H7052 (Oct. 6, 1981) (remarks of Rep. Waxman, manager for the House in the conference). HHS did not respond by changing its new regulations in any respect. Since the Secretary ignored the stated intent of Congress by repealing the "comparability" regulations, and then ignored Congressional protests about that repeal, it is hardly surprising that the Secretary also did not amend 42 C.F.R. § 435.831 to respond to the new one-month income eligibility requirements for AFDC and SSI that were part of the same Act.[22]

The result of the Congressional displeasure with the Secretary's attempts to permit States to budget the medi-

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[22] Section 1396a(a)(10)(C) was amended by Pub.L. No. 97-35, § 2171(a)(3), 95 Stat. 807 (1981). One month AFDC income eligibility determinations were required for the first time by § 2315(a) of that act, 95 Stat. 855 (1981), and quarterly SSI income eligibility was changed to monthly by § 2341, 95 Stat. 865 (1981).

cally needy more restrictively than their categorically needy AFDC and SSI counterparts was the enactment of Section III. It plainly requires that the monthly income eligibility determinations newly required for AFDC and SSI also be used for Medicaid. Nothing in the legislative history contradicts the plain language of the statute, and Congress' intent to prevent the Secretary from allowing States to exercise any "flexibility" supports that plain meaning.

The fact that the 6-month provision of 42 C.F.R. § 435.831 is still on the books is also of no help to the State. The views of the Secretary in support of the regulation's validity are plainly not entitled to any extraordinary degree of judicial deference since the delegation of legislative authority was withdrawn. The history of § 1396a(a)(10)(C), and the Secretary's responses to its amendments, in fact show that the Secretary is entitled to no deference whatsoever on this issue.

Likewise the Secretary's own pre-litigation position concerning the effect of Section III on his regulations completely undermines the notion that the six-month regulation continues in effect. Despite the passage of some 3 1/2 years, the disputed 1981 "flexibility" regulations that prompted Congress to enact the current statute have not been repealed or revised. Why? The Secretary took the position that the 1982 TEFRA amendments are "self-implementing" and have superseded the old regulations without need to repeal or revise them. 47 Fed. Reg. 57775, 57776 (1982). Section III[23] is expressly listed by the Secretary as one of those "self-implementing" and superseding statutes. 47 Fed. Reg. 57775 (1982). Thus the continued existence of 42 C.F.R. § 435.831 is no evidence

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[23] Pub.L. No. 97-248, § 137(b)(8), 96 Stat. 378 (1982).

of its validity. Congress cannot be said to have endorsed that regulation simply because it has not expressly referred to it in the 3 1/2 years since Section III was enacted; the Secretary's assertion that the TEFRA changes were "self-implementing" certainly should have led Congress to infer that 42 C.F.R. § 435.831 had been repealed.

The State fares no better by the alternative arguments that Congress either did not intend to affect the 6-month regulation since it failed to expressly refer to it or that Congress affirmed the regulation by expressly referring to it. These arguments are completely contradictory; this contradiction undermines any weight the State seeks to attach to the legislative history to try to avoid the plain mandate of Section III. The failure of Congress to pass a specific revising amendment does not show that Congress ever thought a particular regulation was correct. *SEC* v. *Sloan*, 436 U.S. 103, 119-122 (1978). The case here is even stronger than in *Sloan*, where Congress was specifically advised of the policy in question. *Id.*, 436 U.S. at 119-120. That is not so here. Since Congress was not specifically apprised of this issue, this case is likewise different from those cited by the United States in its *amicus curiae* brief (p. 16).

The State's alternative argument that Congress expressly reaffirmed 42 C.F.R. § 435.831 misreads the legislative history on which it relies. The House Report[24] on TEFRA stated that the bill "reaffirms the financial requirements *previously in effect* for the medically needy

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[24] H.R. Rep. No. 97-757, Part I, 97th Cong., 2d Sess., at 13 (1982). This statement in a committee report of only one house is entitled to little weight in any event since it was neither repeated in the Senate nor in a conference report. *TVA* v. *Hill*, 437 U.S. 153, 192 (1978).

(42 C.F.R. § 435.800-435.845)." [Emphasis supplied.] The State and the Secretary focus on the parenthetical reference to the series of regulations §§ 435.800-435.845, which appears at first glance to include § 435.831, but they ignore the modifying phrase "requirements previously in effect."

42 C.F.R. § 435.831 had not been just "previously" in effect. Since it had never been amended it was on its face apparently in effect all the while. Congress was merely reaffirming so much of the rules "previously in effect" as had been altered by the Secretary, *i.e.*, those requiring that Medicaid income eligibility determinations be "comparable" to those for AFDC and SSI. There was no need to "reaffirm" § 435.831 since the Secretary had not changed it. The committee report is no more an indication that Congress considered 42 C.F.R. § 435.831 than the rest of the legislative history. It does not support the argument of the State and the Secretary that the 6-month regulation was ratified by Congress.

POINT III

42 C.F.R. § 435.831 IS NOT AUTHORIZED BY 42 U.S.C. § 1396a(a)(17)

The State and Secretary fare no better with their argument that the issue here is not about the methodology for determining Medicaid eligibility based on income under Section III, but rather is about the allegedly separate issue of the length of time the State can use in computing the "spend-down" deduction of incurred medical expenses. The concept of the "spend-down," a term which does not appear in either the Social Security Act or the federal Medicaid regulations, cannot be so easily divorced from the computation of income.

> The spend down requirement does not have a life of its own. It must be calculated over the same period that income eligibility [is] calculated under the categorical assistance program.

Brogan v. *Miller*, 537 F.Supp. 139, 144 n.12 (N.D. Ill. 1982).

This is so because the "spend-down" is simply one of many deductions from income used in determining Medicaid income eligibility. The First Circuit erred in *Hogan* v. *Heckler*, *supra*, by ignoring the fact that the "spend-down" is simply another deduction from income. Since income eligibility must be determined on a monthly basis so must the deductions used in determining income eligibility. The Second Circuit recently recognized this despite its decision in *DeJesus* v. *Perales*, *supra*, when it defined the "spend-down" computation as a "methodology" under Section III in *Camacho* v. *Perales*, No. 85-7139, Slip opn. at 7121 (2d Cir. Jan. 24, 1986) (available Feb. 28, 1986 on *LEXIS* Genfed library, USApp. file):

> The decision that a medically needy applicant will first become eligible for Medicaid when, in a given period his Income minus Medical Expenses = Medically Needy Income Level is likewise an example of a methodology . . . . [Slip opn. at 7149.]

The six-month regulation has always been described by HHS as concerning the determination of income, not the "spend-down." It is currently captioned "income eligibility" and refers to the six-month period as the time over which "to compute income." When first proposed, the "spend-down" regulation concerned the "flexible measure of available income" by taking into account medical "costs incurred"[25] and was in a wholly separate subsection[26]

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[25] *Cf.* 42 U.S.C. § 1396a(a)(17).

[26] 45 C.F.R. § 248.21(a)(2) [1969], proposed at 33 Fed.Reg. 12752 (1968) and adopted at 34 Fed.Reg. 1320-1321 (1969).

from the six-month regulation.[27] That pattern of separating the "spend-down" provision and the six-month income determination provision continued until 1980 when what were described as merely "technical corrections" put the six-month rule into the general introduction to 42 C.F.R. § 435.831 and for the first time encompassed the "spend-down" concept as a subdivision of that general rule.[28]

The six-month regulation cannot be justified as being within the powers legislatively delegated to the Secretary under 42 U.S.C. § 1396a(a)(17) for defining the scope of the "spend-down." Again the statutory language does not support the burden the State and Secretary lay on it. The relevant last clause of § 1396a(a)(17) requires that a State's Medicaid plan

> provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs . . . incurred for medical care or for any other type of remedial care . . . .

That section has nothing to do with the issue here of how many months' income is to be counted in determining Medicaid income eligibility. Rather that section states a general proposition that all costs for medical or other remedial care must be offset against whatever income is

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[27] 45 C.F.R. § 248.21(a)(4) [1969], proposed and adopted as above.

[28] 45 Fed.Reg. 24878, 24881 (1980). Prior thereto the 1968 separation of the two subdivisions was maintained consistently through various proposed and final rules and recodifications, 35 Fed.Reg. 8780, 8791 (1970); 36 Fed.Reg. 3860, 3871 (1971); 38 Fed.Reg. 32216, 32219-32220 (1973); 39 Fed.Reg. 35912, 35917 (1974). A variant on the current structure of the regulation was adopted when the regulations were recodified and revised, allegedly without substantive change in 1978. 43 Fed.Reg. 45176, 45215 (1978); under that version the six-month rule was described as a policy for "determining countable income." 42 C.F.R. § 435.831(a) [1978].

otherwise counted, and then that section delegates to the Secretary the power to put limits on those medical or remedial expenses that States can so deduct.

A few examples show how the Secretary has put limits on the deductibility of medical expenses under that authority and how such policymaking differs from the policy that is at issue here. On its face § 1396a(a)(17) suggests that a Medicaid applicant could count any incurred bills, no matter how ancient; the Secretary has so interpreted the statute, but then has limited it slightly by requiring that the bills must still be current obligations. HHS Medical Assistance Manual § 4-30-30.[29] HHS has now proposed under this authority in § 1396a(a)(17) to further restrict the bills that can be counted to those no more than a few months old. 48 Fed. Reg. 39960, 39961 (1983). Likewise HHS has by regulation[30] authorized States to set limits on the amount of health insurance premiums they will deduct.

Such limits on the costs States must take into account under § 1396a(a)(17) are a far cry from the provision of 42 C.F.R. § 435.831 allowing States to determine income eligibility for a six-month period based on six months' income. The six-month regulation here has nothing to do with limitations on what bills can be counted.[31] 42 U.S.C.

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[29] Massachusetts counts only newer bills, its courts having concluded that the Medical Assistance Manual policy is invalid. *Tinkham* v. *Department of Public Welfare*, 11 Mass.App.Ct. 505, 417 N.E.2d 452 (1981).

[30] 42 C.F.R. § 435.831(c)(2).

[31] An example of this distinction is presented in *DeJesus* v. *Perales*, 770 F.2d 316 (2d Cir. 1985), *petition for certiorari docketed* No. 85-6337 (U.S. Feb. 7, 1986). There plaintiffs were going to have sufficient bills from two hospitalizations to qualify for Medicaid, no

§ 1396a(a)(17) simply does not concern the issue presented here of how long the budget period may be in determining Medicaid eligibility.

CONCLUSION

For the foregoing reasons the judgment of the Supreme Judicial Court should be affirmed.

Respectfully submitted,

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matter how long the "spend-down" period was, for their six-month "spend-down" was well below the cost of only one hospital stay. Their problem was not whether the hospital bills could be counted, or whether the bills could be counted months after the fact, both legitimate issues for the Secretary to regulate under 42 U.S.C. § 1396a(a)(17). Rather, their concern was with how many months of their income would be counted in computing their share of the bills.

APPENDIX

APPENDIX

42 U.S.C. § 1396a [1980]

§ 1396a. State plans for medical assistance—Contents

(a) A State plan for medical Assistance must—

* * *

(10) provide

* * *

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

* * *